

Co-design of contraceptive services in Sweden

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What is the problem?



Almost 1/3 of women giving birth in Sweden are immigrants

Immigrant women report lower use of effective contraception and have higher rates of unintended pregnancies compared to nativeborn women globally and in Sweden^{1,2}

Negative experience of contraceptive counselling^{3,4}

Language barriers & cultural differences⁵

- 1. Emtell Iwarsson, K., et al., 2019
- 2. Omland, G., S. Ruths, and E. Diaz, 2014.
- 3. Zapata, L.B., et al., 2018
- 4. Fox, E., et al., 2018.
- 5. Larsson, E.C., et al. 2016



Ovärdig debatt om familjeplanering för utrikesfödda kvinnor

Debatt • Den senaste tidens debatt om familjeplanering har handlat om att barnafödandet bör begränsas bland utrikesfödda i utsatta områden bland annat i Göteborg, samt om att inte skaffa fler barn än en kan försörja. Är detta en





Ministern: Man ska inte skaffa fler barn än man kan försörja Nästan var femte kvinna född utomlands arbetslös

Valet 2022



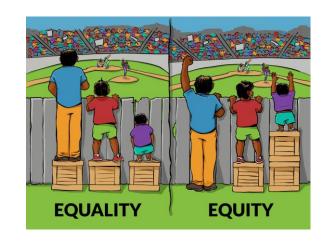
Vården måste försvara reproduktiva rättigheter

Equity



Objectives for public health in Sweden

 The overall objective for public health policy is to create the conditions for good and equitable health among the entire population, and to end avoidable health inequalities within a generation.





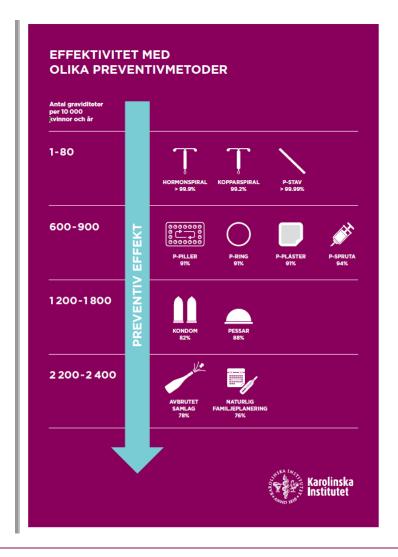
ENSURE HEALTHY LIVES AND PROMOTE WELL-BEING FOR ALL AT ALL AGES

Background

– what seems to work?

- Person-centred care
- Visual tools
- Information about the effectiveness and potential side effects
- Access to methods
- Antenatal and postpartum contraceptive counselling





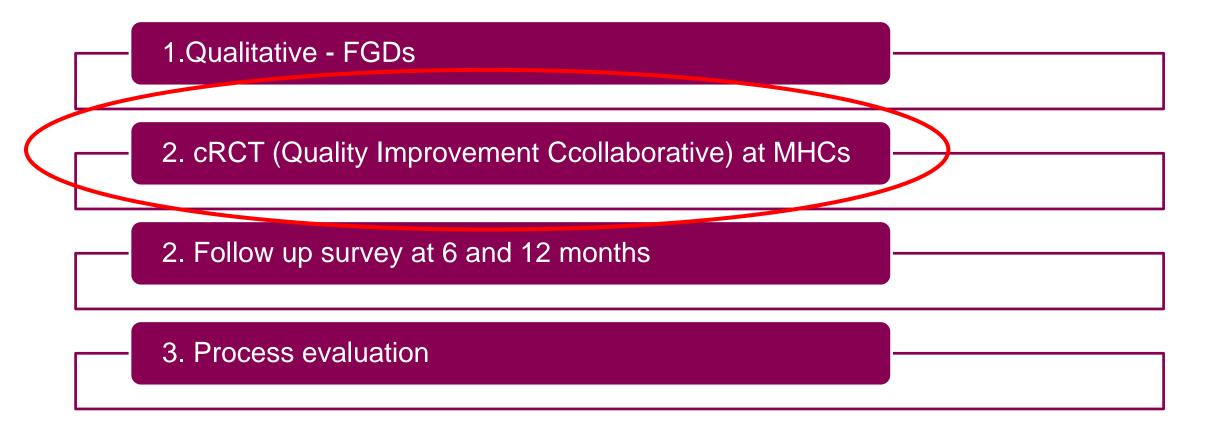


The IMPROVE-it-project

Promoting equitable reproductive health: IMplementing best practice postpartum contraceptive services through a quality imPROVEment initiative for and with Immigrant women, the Target population, in Sweden

Overview of IMPROVE-it





Cluster Randomized Controlled Trial (cRCT)



Aim: To increase women's possibility to choose and initiate an **effective contraceptive method** postpartum

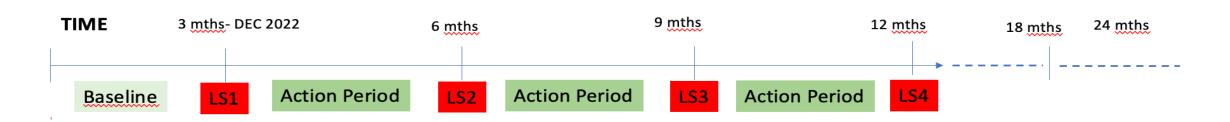
- Method: cRCT, conducted at 14 intervention, 14 control maternity health clinics in:
 - → Jönköping, Stockholm, Västra Götaland
- Participants: Women attending routine postpartum care
- Data collection:
 - → **Main outcome:** Registration of contraceptive method in Swedish pregnancy register
 - → **Secondary outcomes:** Questionnaire at baseline, 6 mths and 12 mths

Quality improvement collaborative (QIC)



Midwives will test and evaluate evidence-based methods

INTERVENTION: Quality Improvement Initiative, incl learning seminars (LS) and continuous Quality Improvement activities during action periods



Each LS:

- Share learnings
- Review data
- Lecture
- Co-design
- Plan activities for action periods



The Intervention: Quality improvement collaborative (QIC)

Features of the intervention:

- 1. Co-design
- 2. Collaboration between researchers, healthcare professionals & patients
- 3. Test evidence-based methods using Plan-Do-Study-Act (PDSA)
- 4. Continuous feedback on data

Quality Improvement?



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 A framework for developing, testing, and implementing changes that lead to improvements

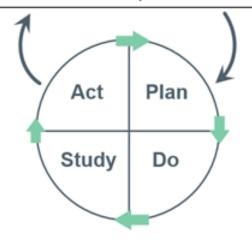
Plan-Do-Study-Act (PDSA)

Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

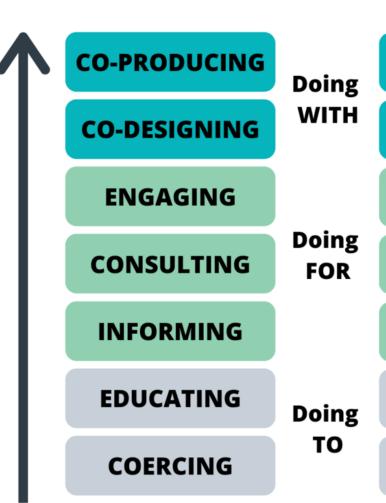


http://www.ihi.org/resources 2024-01-05

Co-design- what is it?

Karolinska Institutet

- An approach to involve stakeholders in the design, conduct, evaluation and improvement of health care services ¹
- Collaboration between users and providers of health care services ²
- Users are considered actors who can take responsibility for their own health and express what they desire from health care services²
- Challenges remain concerning how to involve vulnerable and disadvantaged populations in the present health care system³



EXPLANATION

You work with service users and other organisations from design to delivery. You share all, or almost all, decisions.

You involve service users and other organisations in designing your products/services. They influence decisions but aren't involved in 'seeing it through'.

You give service users and other organisations regular opportunities to express their views in a variety of ways. They can influence some decisions.

You invite service users and other organisations to fill in surveys or attend meetings to say which proposal they prefer or what they think about an issue.

You inform people about your services and explain how they work. Sometimes you tell people what decisions you've made and why.

You educate people on the benefits and rationale of your services. You may try to convince them to act differently.

You require people to use your service or do something without understanding their true wants and needs.

ousiness **lab** 🔊

Credit to Sherry Arnstein, the New Econom

Co-design





- A back and forth process
 - → Online workshops with immigrant target population
 - → Discussion with midwives during the online learning seminars

Co-design activities



Qualitative research

8 FGD: Somali speaking immigrant women

5 FGD: Arabic speaking immigrant women

Development of Personas & Effectivenss chart & counselling methods

Co-design workshops: Somali speaking immigrant women

Arabic speaking immigrant women

Revision of personas/counselling methods shared

Personas used, and input shared in learning seminar with midwives

Development of Charts / Myths and Health benefits Based on LS with midwives

Draft Myths and Health Benefits chart

Co-design workshop Arabic speaking

1 co-design workshop Somali speaking





Thank you- over to Jackie!

Co-designing family planning interventions in Uganda – lessons learned

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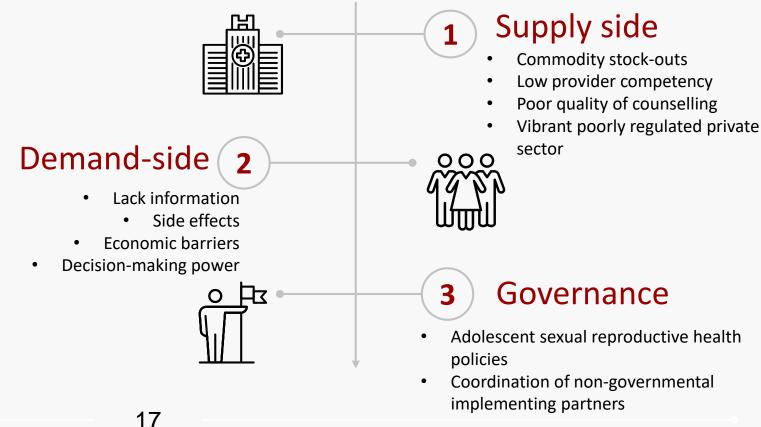


Family Planning Use in Uganda

High Unmet Need

- 20.4% of all women have an unmet need for family planning (FP)
- 25% of women age 15-19 have begun childbearing (UBOS, 2018).
- Intra-urban disparities:
 - Unmet need in informal settlements is as high as 37.3% (Tetui, et al, 2021).

Key challenges



The Urban Thrive Project

- A 3-year project that started implementation in 2021 in Eastern Uganda.
- Aimed at improving coverage and uptake of voluntary FP in emerging urban areas (Jinja City and Iganga town).
- Implemented by Makerere University School of Public Health, in collaboration with Busoga Health Forum.
- Implementation research project implemented in 3 phases:
 1) Formative assessment; 2) Design and implementation and 3) Monitoring and evaluation









Purpose of the co-design process

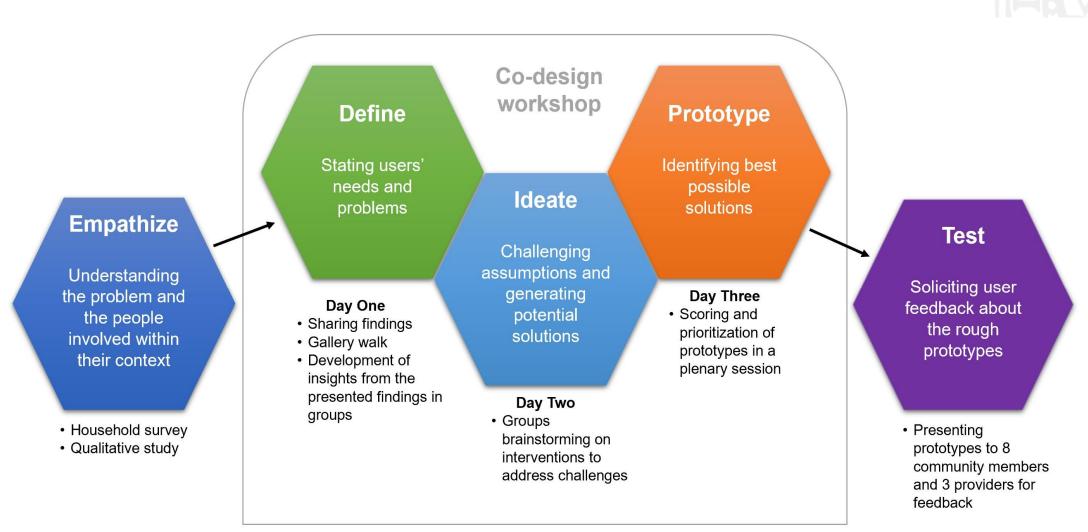
- There is need to tailor interventions to the specific needs of the different sub-populations in urban areas.
- Aimed to actively engage communities to understand community-specific challenges and collaboratively design solutions using the Human-Centered Design (HCD) approach.
- Using co-design, an HCD tool, we aimed to:
 - 1. Identify barriers to the uptake of voluntary FP in urban settings
 - 2. Adapt high-impact interventions that are desirable, feasible, viable, and adaptable for these urban areas:
 - 3. Identify (any new) solutions to address these challenges; and
 - 4. Co-design implementation strategies to effectively deliver the selected interventions.



Methodology



The co-design process



Define

Stating users' needs and problems

Empathize

Understanding the problem and the people involved within their context

- Household survey (3000 men and women)
- Qualitative study (17 focus group discussions and 44 interviews)

Day One

- Sharing findings
- Gallery walk
- Development of insights from the presented findings in groups



Define

Stating users' needs and problems

Day One

- Sharing findings
- Gallery walk
- · Development of insights from the presented findings in groups

Design Challenge 1

How might we increase knowledge and understanding of voluntary FP among women, men, and young people in towns and cities?

Ideate

Challenging assumptions and generating potential solutions

Day Two

 Groups brainstorming on interventions to address challenges

Design Challenge 2

How might we ensure consistent provision of quality voluntary FP services in emergent towns and cities?

Design Challenge 3

How might leaders build the capacity to manage FP programs or create an enabling environment to improve systems for FP provision?

the problem and the people

Understanding

Empathize

involved within their context

- Household survey
- Qualitative study

Define

Stating users' needs and problems

Day One

- Sharing findings
- Gallery walk
- Development of insights from the presented findings in groups

Co-design workshop

Ideate

Challenging assumptions and generating potential solutions

Day Two

 Groups brainstorming on interventions to address challenges

Prototype

Identifying best possible solutions

Day Three

 Scoring and prioritization of prototypes in a plenary session

14 prototypes were developed:

- 8 targeting demandside challenges
- 4 targeted supplyside challenges
- 2 for governance challenges

Understanding the problem and

Empathize

the problem and the people involved within their context

- Household survey
- Qualitative study



Participants worked in 3 groups:

- Community members
- Political leaders and urban health authorities
- FP service providers

Each participant group address all three design challenges.

Groups reported back in the plenary after each session



Co-design workshop Define **Prototype** Identifying best Stating users' needs and possible Ideate solutions problems **Empathize Test** Challenging assumptions and Understanding Soliciting user generating the problem and **Day Three** Day One feedback about potential Scoring and the people Sharing findings the rough prioritization of solutions involved within Gallery walk prototypes prototypes in a their context Development of plenary session insights from the presented findings in **Day Two** groups Groups Household survey Presenting brainstorming on Qualitative study prototypes to 8 interventions to community members address challenges and 3 providers for

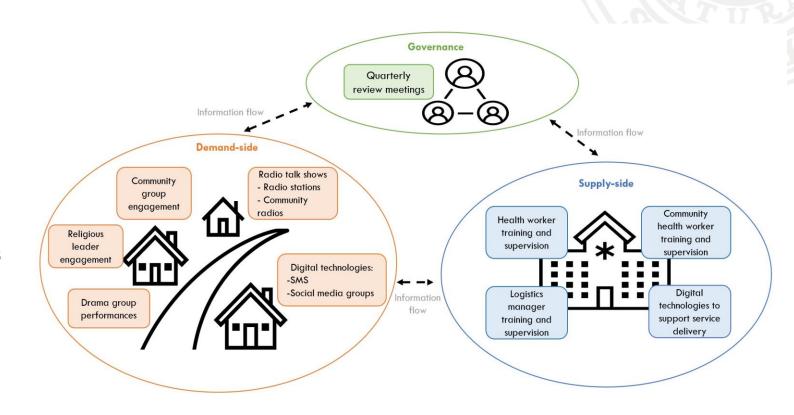
feedback

Feedback from the testing:

- Modifications on some of the prototypes, language and delivery strategies
- An additional prototype to improve client follow-up mechanisms at facilities

Outputs

- A package of 10 interventions was prioritized for implementation.
 - 5 targeted demand-side barriers
 - · 4 targeted supply-side barriers, and
 - 1 addressed governance barriers.
- Birth of the Amazima ku famire planningi or 'the truth about family planning' campaign
 - To address information gaps in client counselling and education about side effects
 - · Integrated in all activities
- Adaptations were made to interventions specified a priori
- New interventions developed



Lessons Learned

- Involving diverse groups of participants provides varied experiences and expertise to develop interventions.
- The language of FP matters
 - Responsible parenthood or manageable family sizes resonates better with communities than fertility reduction
- Communities want complete information about family planning to make informed decisions.
- Consider participant characteristics and power dynamics and their potential impact on the process, especially when engaging diverse participant groups.
 - Community Vs leaders and service providers
 - Adolescents Vs other adults
 - Differences in education level
- Make deliberate efforts to ensure equal representation of, especially, marginalized groups (women, adolescents and urban poor populations)
- Continuous learning and adaptation is crucial!



Thank you!

Urban Thrive Project Team

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